STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING _____ B. WING _____	C 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH CARE CENTER	**7465 MADISON AVE INDIANAPOLIS, IN 46227**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the investigation of Complaints IN00190558, IN00190612 and IN00190668.

This visit was in conjunction with the Recertification and State Licensure Survey.

Complaint IN00190558 - Unsubstantiated due to lack of evidence.

Complaint IN00190612 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00190668 - Substantiated. No deficiencies related to the allegations are cited.

Survey dates: January 10, 11, 12, 13, 14, and 15, 2016..

Facility number: 012225
Provider number: 155780
AIM number: 200983560

Census bed type:
SNF/NF: 84
Total: 84

Census payor type:
Medicare: 10
Medicaid: 62
Other: 12
Total: 84

Sample: 05

Madison Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2.3.1 in regard to the Investigation of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING _____ B. WING _____	C 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH CARE CENTER	**7465 MADISON AVE INDIANAPOLIS, IN 46227**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Complaints IN00190558, IN00190612, and IN00190668. Quality review completed by 14466 on January 25, 2016.	F 000		